RHODE ISLAND DEPARTMENT OF HEALTH
OFFICE OF HEALTH SYSTEMS DEVELOPMENT
LETTER OF INTENT FORM

All applicants must file 3 copies of the Letter of Intent (LOI) form 45 days prior to filing a Certificate of Need application, pursuant to Chapter 15, Title 23, of the General Laws of Rhode Island 1956, as amended, to: Rhode Island Department of Health, Office of Health Systems Development, 3 Capitol Hill, Room 407, Providence, Rhode Island 02908. Please direct questions to the Office of Health Systems Development at (401) 222-2788.

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1. Name and address of applicant, including zip code: _____

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2. Name and address of facility (if different from applicant):_____

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3. Name, address, telephone, e-mail and fax number of Chief Executive Officer: _____

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4. Name, title, address, telephone, e-mail and fax number of person to contact regarding this proposal: _____

_____

5. Brief Descriptive Title of Proposal: _____

6. Brief Summary Description of Proposal: _____

_____

_____

_____

_____

7. Capital Cost of Proposal: _____

First Full Year Operating Cost of Proposal: _____

8. Month and year the proposal would be implemented: _____

9. Will you be requesting:

"Expeditious review" for this application? Yes____ No____ If Yes, please complete **Appendix A**

"Accelerated review" for this application? Yes____ No____

10. Please place an 'X' next to each category that best describes the facility:

___ Hospital
___ Nursing facility
___ Inpatient rehabilitation center (including drug/alcohol treatment centers)
___ Freestanding ambulatory surgical center
___ Inpatient hospice
___ Other (specify) _____

11. Please place an 'X' next to the category that best describes the ownership of the facility.

___ non-profit ___for-profit

12. Please check each and every category that describes this proposal.

A. ___ construction, development or establishment of a new healthcare facility
B. ___ a capital expenditure for
   1. ___ health care equipment in excess of $1,000,000
   2. ___ construction or renovation of a health care facility in excess of $2,000,000
   3. ___ an acquisition by or on behalf of a health care facility or HMO by lease or donation
   4. ___ acquisition of an existing health care facility, if a notice of intent has not been filed with the state agency, or if the services or the bed capacity of the facility will be changed
C. ___ any capital expenditure which results in an increase in bed capacity of a hospital and inpatient rehabilitation centers (including drug and/or alcohol abuse treatment centers).
D. ___ any capital expenditure which results in an increase in bed capacity of a nursing facility in excess of 10 beds or 10% of facility's licensed bed capacity, which ever is greater.
E. ___ the offering of a new health service with annualized costs in excess of $750,000
F. ___ predevelopment activities not part of a proposal, but which cost in excess of $2,000,000
G. ___ establishment of an additional inpatient premise of an existing inpatient health care facility
H. ___ tertiary or specialty care services

13. For each single piece of healthcare equipment in excess of $1,000,000, provide the following:

Type:	Manufacturer's Name:	Model Name & Number:	Cost:

14. Please indicate the financing mix for the capital cost of this proposal. **NOTE:** the Health Services Council's policy requires a minimum 20 percent equity investment in CON projects (33 percent equity minimum for equipment-related proposals).

Source	**Amount**	**Percent**	**Interest Rate**	**Terms (Yrs.)**
Equity*	$	%		
Debt**	$	%	%	
Lease**	$	%	%	
TOTAL	**$**	**100%**		

* Equity means non-debt funds contributed towards the capital cost of an acquisition or project which are free and clear of any repayment obligation or liens against assets, and that result in a like reduction in the portion of the capital cost that is required to be financed or mortgaged (R23-15-CON).

** If debt and/or lease financing is indicated, please complete **Appendix F.**

15. Will zoning approval be required as part of this proposal: Yes____ No____

16. Will this proposal involves new construction or expansion of patient occupancy, that will require an approved plan for water supply and sewage disposal from the state and/or municipal authority: Yes ___ No___

Please have the appropriate individual attest to the following: *"I hereby certify that the information contained in this form is complete, accurate and true."*

_____

Signed and dated by the President or Chief Executive Officer

Appendix A - Request for Expeditious Review

1.) Name of applicant: _____

2.) Indicate why an expeditious review of this application is being requested by marking at least one of the following with an 'X'.

_____a. for emergency needs documented in writing by the State Fire Marshal or other cognizant authority
_____b. for the purpose of alleviating fire and/or safety hazards certified by the State Fire Marshal or other cognizant authority as adversely affecting the life and health of patients or staff
_____c. for correcting conditions which have been identified by the appropriate voluntary accrediting agency as militating against provision of an adequate standard of care
_____d. for a public health urgency to be determined by the Health Services Council.

3.) For each response with an 'X' beside it in Question 2 above, <u>furnish documentation</u> as indicated:

2.a: a written communication from the State Fire Marshal or other cognizant authority setting forth the particular energy needs cited and the measures required to meet the emergency;
2.b: documentation from the State Fire Marshal or other cognizant authority stating that particular fire and/or safety hazards currently exist which adversely affect the life and health of patients or staff and outlining the measures which must be taken in order to alleviate these hazards;
2.c: a written communication from the accrediting agency naming specific deficiencies and required remedies for situations which militate against the provision of an adequate standard of care;
2.d: a complete description and documentation of the public health urgency, which, in the applicant's opinion, necessitates an expeditious review.

Appendix F - Debt Financing

Applicants contemplating the incurrence of a financial obligation for full or partial funding of a certificate of need proposal must complete and submit this appendix.

Name of Applicant: _____

1. Describe the proposed debt by completing the following:
   a.) type of debt contemplated: _____
   b.) term (months or years): _____
   c.) principal amount borrowed _____
   d.) probable interest rate _____
   e.) points, discounts, origination fees _____
   f.) compensating balance or reserve fund _____
   g.) likely security _____
   h.) disposition of property (if a lease is revoked) _____
   i.) prepayment penalties or call features _____
   j.) front-end costs (e.g. underwriting spread, feasibility study, legal and printing expense, points etc.) _____
   k.) debt service reserve fund _____

2. If this proposal involves refinancing of existing debt, please indicate the original principal, the current balance, the interest rate, the years remaining on the debt and a justification for the refinancing contemplated.

3. If lease financing for this proposal is contemplated, please compare the advantages and disadvantages of a lease versus the option of purchase. Please make the comparison using the following criteria: term of lease, annual lease payments, salvage value of equipment at lease termination, purchase options, value of insurance and purchase options contained in the lease, discounted cash flows under both lease and purchase arrangements, and the discount rate.

4. Present a debt service schedule for the chosen method of financing, which clearly indicates the total amount borrowed and the total amount repaid per year. Of the amount repaid per year, the total dollars applied to principal and total dollars applied to interest must be shown.